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The healthcare industry is accustomed to criticism of its deficiencies. Despite medical services of the most technologically advanced, performed by the highest caliber of subject matter specialists, controversy remains in the area of health care coverage. Although the U.S. has avoided major healthcare reform over the past 44 years, the new administration places reform as a priority to achieve in the 2009 legislative session. Within the deliberation, coverage for all Americans is a key topic. Despite a multitude of private insurance companies and federal and state programs, the uninsured and underinsured numbers in American are not declining and those with coverage do not always have access. Various healthcare practices and rising healthcare costs increase the risk of an unsustainable system of care in America. There are many opportunities for change to positively influence costs and improve health including modifications to employer-sponsored insurance, a focus on wellness and prevention and improvements in administrative components. As leaders work to formulate/modify health policy, alliance for action among all stakeholders is essential.

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Changing healthcare industry practices to increase opportunities for covering the uninsured and underinsured

Graduate Management Project Proposal

MAJ Kimberly D. Brenda

U.S. Army-Baylor University Graduate Program
in Health and Business Administration

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Preceptor: Bill Rasco, Col (ret), USAF

Reader: LTC Matthew Brooks, USA, MS

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Abstract

The healthcare industry is accustomed to criticism of its deficiencies. Despite medical services of the most technologically advanced, performed by the highest caliber of subject matter specialists available in numerous facilities, controversy remains in the area of health care coverage for the nation. Although the United States has avoided major healthcare reform over the past 44 years, the current state of affairs and the new administration places reform as a priority to achieve in the 2009 legislative session. Within the deliberation and development of reform, coverage for all Americans is a key topic. Despite a multitude of private insurance companies and federal and state programs, the uninsured and underinsured numbers in American are not declining and those with coverage do not always have access. Various healthcare practices and rising healthcare costs increase the risk of an unsustainable system of care in America. There are many opportunities for change to positively influence costs and improve health including modifications to employer-sponsored insurance, a focus on wellness and prevention and improvements in administrative components. As various leaders work to formulate or modify health policy, alliance for action among all stakeholders is essential. The movement for reform is active. Changing practices to benefit the majority will be tedious. If successful, reform will truly transform healthcare practices making it affordable and accessible to extend a basic level of benefits, ideally, to all individuals in the United States.

Introduction

Healthcare coverage in the United States is a focal point of conflict and confusion among doctors, patients, advocacy groups, insurance companies, policy makers, politicians and lobbyists. These are the stakeholders in a health system with various responsibilities and separate but associated interests. Divergent views in this field are not a new development, as they have existed since the initial concept of insurance and utilization of healthcare services.

At its inception, the intent of insurance was to protect the lost wages during a time of disability or illness. The first evidence of a broad coverage health insurance plan materialized in 1914 as workers' compensation. Voluntary employer-sponsored health insurance was minuscule at this early stage and the insurance companies typically focused on the large industrial populations. The blanket policies included coverage for life insurance, accident, sickness and nursing services. Some considered workers' compensation to be the pilot for the idea of a government-regulated program by reformers who supported national health coverage, and as early as 1916 there were legislative attempts, though unsuccessful, to require employers to provide insurance (Shi & Singh, 2004).

Eventually, the demand for health services by the public did progress as technologic improvements in medical processes increased the perceived value of healthcare. Economically, individuals could predict neither their medical needs nor their medical costs. Therefore, both the increased demand for services and the potential risk of the unknown gave merit to the concept of insurance. As a result, insurance did become the mechanism encouraging the use of health services. With strong opposition, primarily from the American Medical Association, to nationalize insurance, private and commercial insurance grew substantially to meet the needs of the market. Achieved primarily through employer-sponsored programs, by 1950 there were

142.3 million persons enrolled in private health plans. Thus, the industry diminished the voice of advocates for a national plan and employer-sponsored programs became the status-quo in the country (Blumenthal, 2006).

The controversy accompanying the issue is a popular theme today as employer-sponsored coverage faces many challenges. The amount the nation spends on healthcare climbs consistently without achieving the intended benefit of generating a healthier population. While the voice supporting a national plan is amplified once again, it is doubtful concessions will be made to that level of system overhaul because America thrives on capitalism. However, the country is astir with proposals to have both public and private plans offered to promote constructive competition. Overall, the current climate in the nation consists of wide agreement that America cannot simply continue down the business as usual path of healthcare delivery, but needs to commit to being re-oriented in approach, practice and delivery as put forth by Dr. Robert A. Berenson's testimony (*Health reform in the 21st century: reforming the health care delivery system*, 2009). No longer can the 'non-system' afford to turn a blind eye to growing numbers of individuals without a base level of care, unrestrained costs, poor outcomes, regulations too numerous or impractical to manage and mismanagement of chronic conditions. Although the financial conditions are turbulent, "there appears to be wide interest for such reform" that confronts the discrepancies and inefficiencies in healthcare (Carey & DeMichelis, 2008).

Now more than ever, the subject is a tinderbox, especially with a new President and new Congress at the helm. No matter the potential slant, the discord over possible solutions to extend insurance to more people in the United States, in essence, aggravates the healthcare coverage dilemma. With protracted disputes over the level and amount of care to offer as public versus private, America sits virtually at an impasse. Meanwhile, with no alliance to action, the chasm

widens between the healthcare for those with coverage and those without coverage as many people with legitimate healthcare needs experience delayed access or go without care that may worsen their medical condition. Others, who simply cannot wait, find themselves in dire financial straits.

The problems associated with cost, access and quality are intertwined and there are multiple stakeholders in the battle making it increasingly difficult to affect change in this issue. Modification has taken place through incremental methods since the most radical change occurred to healthcare in 1965 when President Johnson signed Medicare and Medicaid into law. Since that time, the U.S. has avoided major reform and the practice of healthcare generally is the same. Additionally, the consequences of inaction to cover the uninsured/underinsured are obscure. However, these are not reason enough to declare no need for change and forego preparation for exigent circumstances.

Now, the possibility of major reform looms, especially since the current administration is announcing that they may use the budget reconciliation process to ensure that there is reform this year. This process allows legislation to move through the Senate without the threat of a filibuster and limits debate to 20 hours. Thus, it has a very partisan approach and does not bode well for those desiring to work on compromise regarding such a serious subject.

Ideally, solutions are prudent and bipartisan when revision on a large scale is the plan. It will be no small task to develop reform that will achieve the goal of increasing the number of individuals with insurance and at least maintain the current level of access to medical services while reining in the spiraling costs of healthcare. To accomplish this with straightforward implementation and without excessive addition of new regulations or mandates is truly challenging . Yet, a nationally sponsored program would no doubt increase regulation and

mandates substantially, as history illustrates in the case of Medicare and Medicaid programs. Rushing healthcare reform via reconciliation is not viewed as the best mechanism to achieve positive changes, but it may be done.

To maintain the principles of a free-market in the business of healthcare, one might expect confrontation with the various stakeholders who posture themselves to protect their lane of interest as well as their return on investment. The stakeholders with the most resources have finely honed skills in navigating adversarial waters or their financial resources have influence on decisions or both. Either way, this leaves room, traditionally, for only incremental changes, which can sufficiently produce constructive results in various areas. However, America needs to expedite the process of working together on a solution since, as mentioned previously, there is a possibility healthcare reform may be accomplished through budget reconciliation.

The more plausible trajectory for America to achieve swift policy reform with far-reaching and positive transformation, is to develop a series of targeted, carefully selected and compatible incremental proposals that will produce a synergistic effect in which the combined benefit is more advantageous to society than any one large scale plan. Given the nature of the healthcare challenge, this calls for potential policy solutions to balance incentives and disincentives and prepare to offset their personal ideologies and interests to formulate a policy and coordinate a coalition to promote effective and efficient implementation. Ultimately, there will be no perfect plan that will not have unintended consequences and there is no perfect time to act, but America needs to take steps forward despite the unsettling terrain that lies ahead.

Circumstances warrant a shrewd plan of implementation directed toward the major pitfalls that currently exist in the system and the chief health concerns influencing overall costs.

In the report, *America's Uninsured Crisis: Consequences for Health and Health Care*, the Institute of Medicine (IOM) emphasizes the urgency to move forward on this issue.

> It is now 5 years since the IOM made its recommendation, and there has still been no comprehensive national effort to achieve coverage for all Americans. A severely weakened economy, rising healthcare and health insurance costs, growing unemployment, and declining employment-based health insurance are all evidence that the U.S. health system is in a state of crisis. There is no evidence to suggest that the trends driving loss of insurance coverage will reverse without concerted action. (IOM, 2009).

This paper will review evidence to justify the need to transform current practice and illustrate the importance to take action when there is a window of opportunity in the legislative environment. Additionally, the information presented will explore new care models for potential implementation. Although many pressing matters exist, the information presents the importance for the healthcare industry to take action offensively so Texas might lead the way for investing in the future of America.

Evidence

Estimates

A major topic in healthcare is the number of uninsured individuals. The numbers of uninsured receive ardent interest in policymaking. Although estimates vary between the usual four federal and two private sector surveys that report on these statistics (Appendix A), results are typically consistent between these six surveys. However, the Current Population Survey (CPS) conducted by the U.S. Census Bureau "is the only source for all 50 states" (HHS, 2005).

The latest available U.S. Census Bureau report *Income, Poverty, and Health Insurance Coverage: 2007* states the nationwide number of uninsured is 45.7 million (15.3% of the

population), a slight (0.5%) decrease from the previous census which placed the 2006 estimate at 47 million (15.8% of the population). Although that decrease seems like a change in the right direction, the numbers in other areas worsened. In the case of employer-sponsored insurance (ESI), coverage dropped by 0.4% and those who entered the government health insurance programs increased by 0.8%. This is not necessarily an overall positive change. This same report reveals 25% of Texans are uninsured, listing Texas as the state with the highest percentage of uninsured (DeNavas-Walt, Proctor, & Smith, 2008).

The underinsured must be included in this review as well, This growing segment of the population has considerable financial and physical consequences similar to those of the uninsured. There is a variety of definitions for "underinsured", but this paper uses the criteria found in one of The Commonwealth Fund studies. The underinsured are those with an income above 200% of the federal poverty level (FPL) and out-of-pocket spending of 10% or more of household income on healthcare (http://aspe.hhs.gov/poverty/08Poverty.shtml, retrieved March 10, 2009). To clarify the dollar equivalent, the latest FPL issued by the Department of Health and Human Services is in Table 1.

2009 HHS Poverty Guidelines			
Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,830	$13,530	$12,460
2	14,570	18,210	16,760
3	18,310	22,890	21,060
4	22,050	27,570	25,360
5	25,790	32,250	29,660
6	29,530	36,930	33,960
7	33,270	41,610	38,260
8	37,010	46,290	42,560
For each additional person, add	3,740	4,680	4,300

Table 2. 2009 Health and Human Services Poverty Guidelines.

[1] From United States Department of Health and Human Services, retrieved April 1, 2009.

Those with a low-income status (200% below the FPL) are considered if out-of-pocket spending is 5% or more of household spending or if deductibles equal or exceed 5% of income. With these parameters, The Commonwealth Fund research estimated 25 million adults, ages 19 and older, were underinsured in 2007. This was a 60% jump in the number of underinsured from the study conducted in 2003 (Schoen, Collins, Kriss, & Doty, 2008).

More reason for concern is that the numbers available for this paper do not reflect the recent downturn of the economy. For example, the research by the Urban Institute calculated that "1 percentage point rise in the national unemployment rate can be expected to increase Medicaid and SCHIP enrollment by 1 million people" and possibly exhaust state resources like an SCHIP block grant (Dorn, 2008). Additionally, any steps to defray Medicaid costs, due to an increase in enrollees, will likely tap into state money initially set aside for education or infrastructure. Considering the average unemployment rate for the first quarter in 2009 is 8.1%, an increase of 1.6% from the fourth quarter average in 2008, Texas has reason to be apprehensive. This is also reason to actively engage in offensive and defensive planning to protect the welfare of Texans (http://www.bls.gov/news.release/pdf/empsit.pdf, retrieved January 7, 2009).

Casting a shadow on overall U.S. practices is the exorbitant amount of America's National Health Expenditures (NHE) that is simply not producing desired results. In 2007, the United States' health care bill reached $2.2 trillion (CMS, 2009) and topped the list for total expenditures on the health and welfare of its people when compared to other nations as evidenced by 15.2% of GDP (WHO, 2008). Yet, the U.S. lags behind other developed countries in terms of healthcare indicators (Appendix B).

Another think tank, the Organization for Economic Development (OECD) corroborates this point and reports the United States, as of 2005, spent "two and a quarter times the average of

OECD countries". Despite the amount spent on healthcare, the OECD vital statistics show the United States ranking lower than most OECD countries. For example, the U.S. is 24th among 30 countries regarding life expectancy at birth, 14th for life expectancy at age 65 and ranks 23rd among 27 countries for mortality from heart disease and stroke to name a few (OECD, 2007). Yet, national health spending shows no sign of slowing. With an estimated rate of growth at 6.2% each year from 2008 through 2018, the NHE is projected to reach almost $4.4 trillion by 2018 and outpace Gross Domestic Product (GDP) which is estimated to decrease by 0.2% this year; the first decrease since 1949 (http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf, retrieved January 25, 2009).

Although this presents a negative scenario, one must consider work that illustrates that OECD statistics are not necessarily immediate cause for concern in the United States. A National Center for Policy Analysis reports, "The US compares more favorably when real resources are measured rather than monetary accounts. Per capita, the US uses fewer physicians, nurses, hospital beds, physician visits, and hospital days than the median OECD country" (Goodman, Gorman, Herrick, & Sade, 2009). Other discussion in the report suggests that due to the suppression of normal market forces throughout the developed world, buyers seldom know the real price of medical services and it is common practice to disguise costs by suppressing provider incomes (Goodman, et al., 2009).

In any case, there is agreement in the majority of research that the U.S. national health spending is soaring and America needs a prescription to curb costs. If not controlled, these costs do have a real effect: it will increase the uninsured and constrict those who are insured (Emanuel, 2008a). More specifically, the rising cost will threaten the viability of medical facilities, siphon

the state's budget for healthcare programs, and impede the ability of businesses to offer insurance and pensions. All of which diminishes resources supporting access to healthcare services. Thus, cost and access are irrevocably intertwined and having access is the first step to achieving some level of quality in the well-known "Iron Triangle" model of healthcare. That said, it is important to review some facets of access and quality as well.

Access and quality

In the aforementioned model, cost is the most objective of the three measures. In access and quality, there are subjective differences and varying levels of distinguishing characteristics for the determination of access and quality, but the healthcare industry attempts to provide some guidance and standards that can generally be applied to defining access and quality. The Institute of Medicine (IOM) defines access as "the timely use of personal health services to achieve the best possible health outcomes." The definition of quality is "the degree to which health services for individuals increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (IOM, 1993).

Where things begin to blur in the battle for health care coverage for all is that there are still no guarantees that coverage will absolutely provide timely access to quality care or improved health. Yet the efforts are not in vain, as there is extensive research to show that coverage improves the chances of a person receiving adequate access to care, making the effort worthwhile. Research by John Hadley, reviewed multiple studies on the relationship between health and having insurance (access to care). His findings supported the idea frequently cited that insured individuals are healthier, have higher work force participation and higher income (Hadley, 2003). Another study, shows Medicare and Medicaid spending could be reduced if the

previously uninsured beneficiaries received coverage beginning at age 55. A delay in care until eligibility at age 65 results in more costly healthcare (Hadley & Waidmann, 2006).

The Institute of Medicine (IOM) suggests the lack of health insurance coverage provides partial explanation for the poor U.S. rankings in areas such as the *deaths amenable to medical care* of the WHO statistics. The IOM estimates adults 64 years of age and younger have a 25 percent greater mortality risk than those in the same category with health care coverage. This is equated to approximately 18,000 deaths, a number comparable to the 2001 figures of individuals who died from diabetes (17,500 deaths) or stroke (19,000 deaths) in the same age group (IOM, 2004). The IOM obtained the evidence through reviews of longitudinal population-based research (research following an original population over a period of time) with overall consolidated figures available in Table 2. Though some contest the applicability of the IOM findings, these statistics are commonly cited in credible research journals and government and private sector reports.

Uninsured Adults Are More Likely Than Insured Adults To Die Prematurely

Age	U.S. Population, 2000 (millions)	Percent Uninsured (within age group)	Deaths per Million, 1999 (estimated)	Total Deaths Estimated for 2000 Population	Estimated Excess Deaths for Uninsured Adults
25-34	37.4	21	1,083	40,548	1,930
35-44	44.8	15	1,992	89,202	3,431
45-54	38.0	12	4,273	162,545	4,734
55-64	23.8	14	10,219	243,049	8,219
Total	**144.0**	**16**	**3,717**	**535,344**	**18,314**

Table 2. Uninsured Adults Are More Likely Than Insured Adults To Die Prematurely

[2] From Institute of Medicine (2002). Care Without Coverage: Too Little Too Late. Washington, DC: National Academies Press.

In defense of what many call a crisis, some point out every person, technically, does have access to healthcare via the Emergency Medical Treatment and Active Labor Act (EMTALA). The intent of this law is to curtail "patient dumping" and mandate that care be given to those who present to the emergency department (ED) regardless of ability to pay. It is the drain on financial resources from providing uncompensated care to the un/underinsured at this particular point of service often cited as an influential driver of increases in insurance premiums and a reason to cover the uninsured; to save the burden on society. In this case, uncompensated care is defined as the value of care received by the uninsured that is not paid for out-of-pocket and the amount not paid to the hospital.

Such an argument is made in a report that posits the "average premium for family health insurance provided by an employer was $922 higher in 2005 due to the cost of health care for the uninsured that they could not afford to pay themselves" (FamiliesUSA, 2007). With this rationale, the primary culprit is viewed to be the care provided to the un/underinsured being offset by the hospital through an increase in charges to payers (insurance). This cost then shifts to the insured population in the form of higher premiums charged to those with insurance. In turn, this perpetuates an increase in the number of individuals at risk for losing coverage. Thus, with another increase in uncompensated care the cycle of increasing premiums will continue (FamiliesUSA, 2007).

However, a report prepared for the Kaiser Commission, illustrates an opposing concept and states, "there is also a malignant interpretation: higher payments by privately insured patients to pay for the uncompensated care eventually translate into higher premiums for private insurance" (Hadley, Holahan, Coughlin, & Miller, 2008). The following excerpts further explain the authors' support of this alternate view:

> "-Total uncompensated care represents 2.2% of total health care spending estimated for 2008. This is a much smaller share of total spending than the uninsured's share of the total population because the uninsured use less care than the insured (holding health status constant), because they pay for much of their care themselves.
>
> -Taking the entire population into account, insured adults (including the elderly but excluding people covered by Medicaid) spend about $350 per person through taxes, donations and payments for private health care and private insurance to subsidize care received by the uninsured.
>
> -Even if all private funding for uncompensated care were recouped from private insurance payments, this would still amount to only 1.7% of private insurance premiums" (Hadley, et al., 2008).

Therefore, it may be better to argue that the U.S. is in need of more parity with certain levels of care throughout the country to keep the emergency departments (EDs) available for their intended purpose so they run efficiently which is more cost effective.

For example, increased frequency of visits to the ED as a substitute for primary care or as a last resort to stabilize complications from a chronic condition that did not receive routine management duly illustrates why relying on EMTALA is not adequate. Although there are some exceptions, if the un/underinsured have a better source of healthcare coverage, they would seek care earlier through a primary provider and receive services. This would generally lead to less expensive care and prevent an urgent situation from developing that is potentially more costly. Timely access is a more accurate justification in the discussion regarding ways to decrease overall hospital costs when assessing this specific trend of improper ED use versus taking the position that an increase in premiums from this point of care is the main concern.

America did not get into this healthcare quandary of exploding costs and millions of un/underinsured individuals overnight and one cannot expect to quell the multitude of obstacles contributing to cost with one act. Accounting for the rising costs includes an almost inexhaustible number of catalysts that perpetuate the problem. Aside from the complexity due to the number of contributing factors, the inherent difficulty of working on a solution is that factors often intersect and efforts to ameliorate one cost driver may impinge on the resources supplied to another.

Although the patient should be the focus, the practice of medicine subsumes capitalism and just these few matters in disarray afflicting the bottom line, by default, afflict the patient as well. Inevitably, the fiscal goal can quickly hinder potential progress as interest groups develop competitive versus collaborative agendas. Albeit, one must acknowledge cost may have a better chance of motivating employers, competitors and government officials than moral obligation. However, it is imperative that cost is simultaneously included with reform to broaden coverage. It would be counterproductive to consider a single focus for reform. Instead, there needs to be a strategic and judicious plan because "expanding coverage and then worrying about controlling costs, as was done in Massachusetts, is not a tenable policy" (Emanuel, 2008a).

Keep in mind, Texas has one of the fastest growing populations (14.6% increase from 2000 to 2007), with concurrent increases in the uninsured population (http://www.prb.state.tx.us/Karl%20Eschback.pdf, retrieved December 13, 2008). Since the healthcare industry needs to provide services to keep up with the growth, Texas needs to be ready to address the challenges. One Texas county is attempting to address these challenges. Through interviews with CareLink personnel, the information below summarizes Bexar County efforts (S. Balderrama, personal communication, January 20, 2009).

CareLink began in 1997 and is managed by the University Health System (UHS). UHS is the one public hospital in the county and is supported, in part, through property taxes that are put toward the Tax Fund. This is the primary financial resource for CareLink programs.

CareLink serves as a financial assistance program and a network of providers to facilitate access to medical care for the Bexar County residents who are without insurance and do not qualify for other public programs, as it is intended to be the payer of last resort. The program has changed through the years and today provides substantial benefits to members including: preventive care, family planning, primary care, hospital services, outpatient services and health education, mental health services, emergency care and prescriptions. By increasing case management, cost-benefits have improved. By far, one of the most impressive aspects of the program is the personal accountability of patients to participate in payment of the healthcare services received, depending of what category for which they qualify. This improves the level of services CareLink can provide since some of the money from the Tax Fund is returned by patients who otherwise would have possibly gone to the ED and never paid a cent, further depleting resources to help cover healthcare costs in the county. Still, due to fiscal limitations, CareLink cannot cover all the indigent in Bexar County, but serves an admirable amount of residents. In 2008, CareLink had a reported 55,000 members and $12 million was paid back into the Tax Fund.

As valuable as CareLink is, all individual counties and the state could do more to address the challenges that are of almost epic proportion. The platform is available now to launch some change in the Texas. This year, 2009, the 81st Legislature of the State of Texas began when it convened on January 13th. Sessions only assemble every other year, but Texans need to be diligent to the cause of seeking to reform healthcare practices and improve affordability of

coverage to Texans. This is the opportunity to address sensible cost-containment through increased efficiencies and begin making healthcare affordable or at least curtail the rate of increase.

Complexities of the insurance market

One area that could benefit from improvements in efficiency is the health insurance market. Plagued by issues, this third-party mechanism of payment, oftentimes is an agent of confusion between the patient and the provider. Health care insurance quickly distorts the consumer's sensitivity to the price of medical services received. It is not only perplexing to the patient, but encumbers the physician and hospital functions as well. Modifications to decrease confusing regulations, streamline processes, improve transparency of transactions, and simplify consumer options are needed. If incorporated into the insurance industry, these changes could decrease administrative burdens, boost cost savings, and help improve affordability of coverage for individuals and families.

Many of the complexities begin with the two fundamental building blocks of the insurance market, pooling and coverage. Pooling is based on ratios, the higher the ratio of young and healthy versus older and ailing enrollees, the lower the overall costs; the lower the ratio, the higher the costs. Coverage design involves determining the deductible, coinsurance and copayment amounts. Coverage may be limited or comprehensive and may have annual or lifetime maximum limits. There are different classes of insurance and within each of those classes are categories and various services that may have specific exclusions or waiting periods. These nuances to insurance and the amount of competition in the market influence cost.

If that was not convoluted enough, the Code Red Task Force points out the "scope of discretion accorded insurers to make final and binding coverage determinations with broad

discretion to construe the terms of the agreement" adds to consumers' frustration (*Code Red: The critical condition of health in Texas*, 2006). Unfortunately, efforts to improve processes, expand or improve coverage through regulation potentially backfire by adding to the costs for those already covered. Rules and regulations, such as House Bill (HB) 610, are intended to improve the timeliness and efficiency of payment by outlining what qualifies as "preauthorization", "precertification" and "clean claim". However, the obstacles from insurance jargon and stipulations, the variations between forms of insurance, and the quantities and types of insurers and payers add an overwhelming degree of difficulty to the process (Appendix C). This necessitates medical facilities directly hire or contract additional administrative personnel to bear the burden of proof when an insurance company delays or denies claims because it takes a great deal of time to sort through the regulation quagmire and help the medical facility and patients manage claims.

When the situation does not warrant receiving assistance from hospital personnel, the individual must go through the fatiguing process alone and the individual often is the loser. This paper does not begin to address some of the unethical practices such as "cherry picking" healthy enrollees in an attempt to reduce the number and monetary amounts claimed. However, it is easy to grasp that dealing with insurance companies even when they do follow the rules is still much too confounding and needs simplification. Is it improbable to purport that if streamlined and made easier to maneuver in the insurance market there would be more time to place emphasis on the patient versus the patient's system of payment with the added cost-savings benefit?

This is a reason the single-payer system (the Canadian health system is an example of a single-payer system), garners some support as an optimal choice. In this system, the regulation and funding of all aspects of healthcare are nationalized, creating a single organization of

guidelines to follow. It seems simple and data showing that U.S. public programs, Medicare and Medicaid, have lower administrative costs than those of private insurance claim the single payer system will lower health care spending. Additionally, some comparisons between the U.S. and Canadian administrative costs defend this option. However, an economist from the National Center for Policy Analysis exposes that hidden costs shifted to providers and tax collection to fund public insurance are not included. He estimates the upshot of a universal Medicare program "using the most conservative estimate of the social cost of collecting taxes," would double the administrative costs of universal private coverage (Goodman, et al., 2009). Perhaps the single-payer system would simplify structure, but it will not necessarily help costs. Therefore, it is important to continue to evaluate other areas within the system we have now.

Employer-Sponsored Insurance (ESI)

Another area that needs assessment and revamping is Employer-Sponsored Insurance (ESI). While the current economic predicament only exacerbates the situation of unemployment and unemployment is certainly a risk factor for being uninsured, reality is that the working family accounts for the highest number of uninsured. One study reported approximately 79.3% individuals (full-time and part-time employed) were without insurance during 2006-2007 (FamiliesUSA, 2007). While presumed the status-quo mechanism for acquiring health insurance, employment does not guarantee health care coverage, a paycheck does not equate to being able to afford coverage and what one can afford to purchase does not equate to adequate coverage. Admittedly, health insurance is not the panacea for access to medical services. However, for this analysis, because having a form of health care coverage is a step in the direction toward easier access, distinct separation between the two does not necessarily occur consistently in literature reviews of this subject.

America is accustomed to the idea that a majority of jobs come with health benefits as a form of compensation. However, an increasing number of workers find it difficult to afford the health insurance sponsored by their employer. The average annual premium for family health insurance increased by more than 90 percent between 2000 and 2007. The employee's annual share of that premium rose on average from $1,656 to $3,281, a greater than 98 percent increase (FamiliesUSA, 2007). Worst case, the employer discontinues offering health benefits altogether. This is just one example of a change in trends resulting in declining coverage and bringing attention to the dysfunction and limitations in the system.

A particular area of imperfection with ESI is that it adds to the misperception of employees who think the cost of coverage is shared and that the employer pays for the majority of premiums. However, the tradeoff disclosed in many economic studies is that "[workers] bear the full cost of the premium increase" as stated by Baicker and Chandra who reported a 10% increase in premiums brought about a 2.3% decline in wages (Baicker & Chandra, 2006). Along the same lines, individuals have a misunderstanding that the "government" is paying for Medicare, Medicaid and other public programs. In fact, to pay for programs, the government only uses current taxes or "borrows from future tax payers," or takes money from one service to pay for another service. Regardless, the individual or household pays. According to Emanuel, "Failure to understand that individuals and households actually foot the entire health care bill perpetuates the idea that people can get great health benefits paid for by someone else" (Emanuel, 2008b). This lack of knowledge, at a time when Congress is at the verge of voting in new healthcare policies/laws, interferes with "the public's willingness to tax itself for the benefits it wants" (Emanuel, 2008b).

In precarious economic times with conflicting analysis among researchers, consumers could benefit from more availability of accurate and comprehensive information. Increased transparency in the insurance industry would help educate the consumers and policy makers to determine inefficiencies or improper practices to address and correct. Some non-partisan organizations have implied that mandatory reporting would reveal an alarming amount of premiums paid into insurance companies are used to cover out-of-state claims versus covering claims for Texas residents. It is suggested, should this information be validated through transparency, Texas would be better off to create a policy that premiums paid in Texas were only used to cover state residents. Thus, creating revenue to increase coverage and expand benefits.

Another avenue of approach to cover more individuals would be to reconsider the age that parents/guardians must discontinue including their children in their insurance plans. Current Texas law requires fully-insured group and individual health plans to allow parent to continue coverage of unmarried dependents until they turn 25, regardless of school or work status. Although this age limit is higher than some states, it is proposed that as long as parents choose to pay the premium to cover their children, it should not be an area of contention. Research seems to validate growing momentum for this change and little reviews of opposition. For this reason, it may be "low hanging fruit" and easier to implement than other recommendations.

Currently, insurance regulation is in sunset review, so the window of opportunity is truly open for major alterations to the insurance market. Accounting for the rising costs in health care includes an almost inexhaustible number of catalysts that perpetuate the problem. However, widely accepted is the relationship between high health care costs and high insurance premiums and high numbers of un/underinsured. Therefore, any legislative changes for the positive in one area, would be a success in the other areas as well.

Redundancy of monitoring agencies

Complying with multiple regulations and different payers creates an expensive administrative bureaucracy that diverts resources away from contributions to patient care and improvements in the affordability of healthcare. The redundancy alone in various areas monitored by multiple agencies is a prime example of wasteful efforts in the name of quality, safety and transparency that overlap one another and add to the nation's healthcare bill unnecessarily. Figure 1 illustrates the convoluted web of state and federal regulating agencies.

Sample of Agencies Regulating Hospitals at the State and Federal Levels

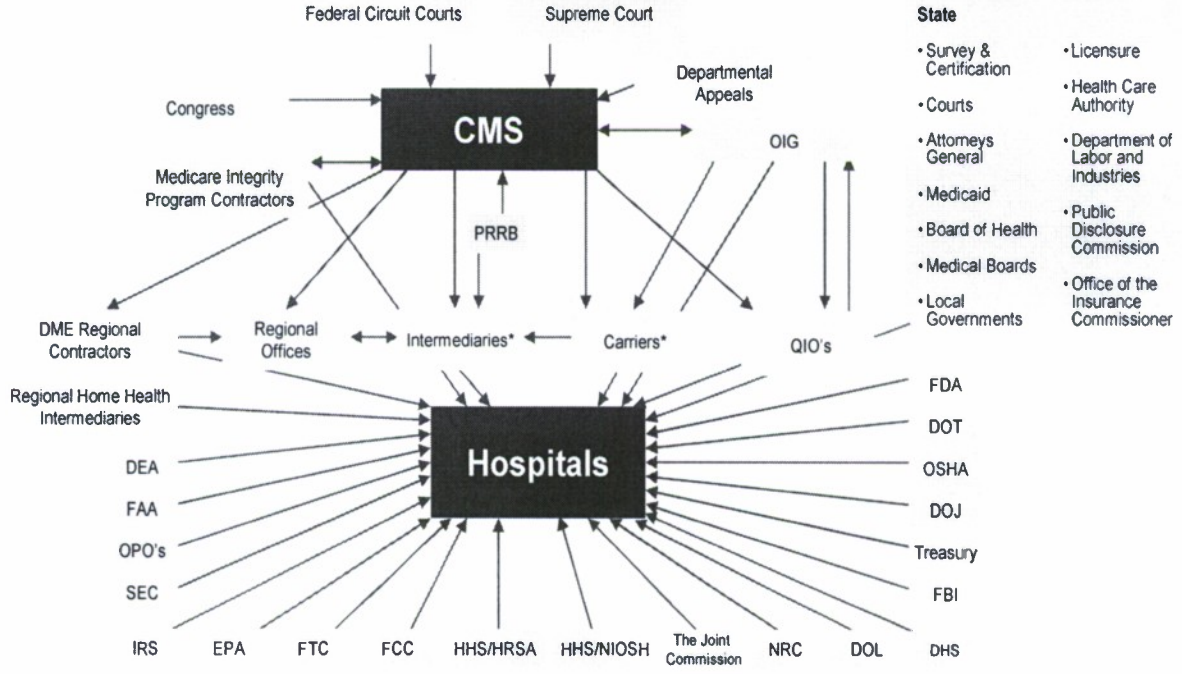

Figure 2. 2009 Sample of Agencies Regulating Hospitals at the State and Federal Levels.[3]

[3] From American Hospital Association, retrieved March 30, 2009.

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mandatory and voluntary quality programs exist, as well as pay-for-performance programs.

After examination of the countless number of administrative components, it is reasonable that The McKinsey Global Institute reported 21% excess spending on health administration and insurance in 2003 of the total excess spending of $477 billion (Angrisano, Farrell, Kocher, Laboissiere, & Parker, 2007). Utilizing those statistics, economist Uwe E. Reinhardt states "Brought forward, that…would amount to about $150 billion in 2008" (Reinhardt, 2008). Therefore, minimal increases in efficiency that reduce the need for additional administrative personnel, potentially translates to considerable savings.

Application of the same fundamental principle of production theory used to represent the total product curve for medical care may be useful in analyzing the relation between quality and quality monitoring/auditing. Substituting quality for health and medical care for quality monitoring/auditing and assuming all other factors constant, the total product curve implies that quality is positively related to the amount of quality monitoring/auditing. However, this also reflects the law of diminishing marginal productivity and implies that quality increases at a decreasing rate with respect to additional amounts of quality monitoring/auditing. Therefore, one can postulate that increasing the number of quality monitoring/auditing agencies with which hospitals must comply does not necessarily generate an increase in quality.

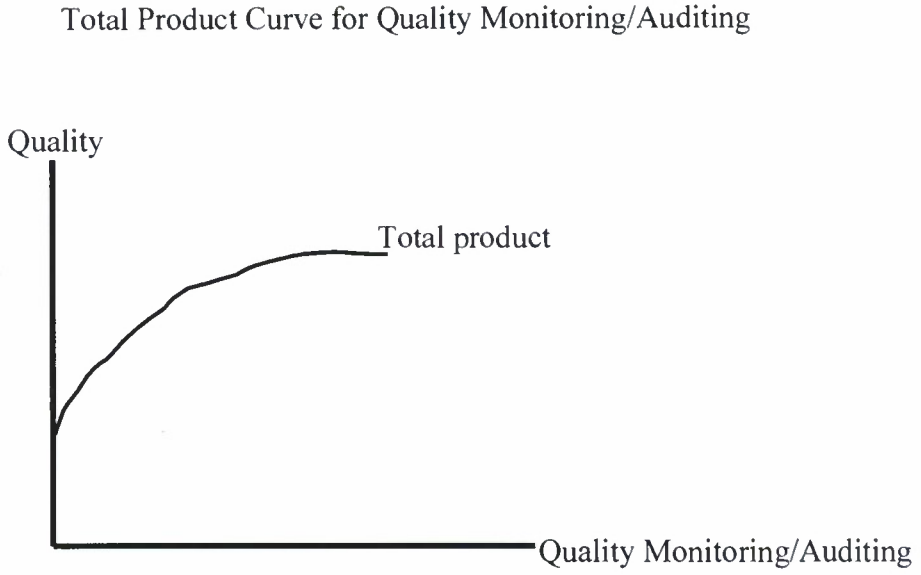

Figure 3. Total Product Curve for Quality Monitoring/Auditing

4 Adapted from Santerre, R. E. & Neun, S. P. (2007). Health Economics. (4th ed.). United States: Thomas South-Western.

Clearly, the layers of different regulatory entities contribute to the inherent difficulty of working on a solution. Any motion to ameliorate duplicative cost drivers is expected to be challenged considering agency employees have a vested interest in maintaining their area of oversight, regardless of waste. The ramification of too many monitoring agencies without elimination of overlapping requirements constricts the resources of hospitals, burdens personnel and may actually negatively effect healthcare for consumers.

Lack of emphasis on wellness and prevention of chronic disease and obesity

Chronic diseases qualify as the subtle behemoth among medical challenges today. The statistics elucidate that prevention and management of chronic disease must be a primary focus for the U.S. health system if there is ever to be a reasonable opportunity to harness the costs of healthcare, improve the health status of generations to follow to cultivate and sustain a productive U.S. workforce. Currently, the outlook is not positive regarding this colossal

contributing factor to the cost of healthcare. Moreover, many leaders are missing the more relevant issue, which is "how much value is achieved for any given prevention or treatment service" and instead of debating what saves money, determine cost-effective methods to improve population health and get the most benefit for the money spent (Goetzel, 2009).

Steadfast effort is necessary to solve this problem for the sake of the health and economy of the nation. A healthy workforce is needed for the future. Yet, considering just one of the population issues, the increasing prevalence of childhood obesity, some researchers predict a reversal of the trend of an increase in longevity for a future generation. These longevity forecasts play a key role in setting policy for entitlement programs with age criteria.

It would be incorrect to presume a decline in life expectancy would somehow ease the burden on the age-based entitlement programs when, in fact, it would be "at the expense of the economy in the form of lost productivity before citizens reach retirement and large increases in Medicare costs associated with obesity and its complications" (Olshansky, et al., 2005). Until prevention and wellness receive the appropriate intensive focus to prevent individuals from developing these diseases in the first place, chronic conditions will continue to result in serious complications, especially if not properly managed, that are debilitating to individuals and add to the rising costs.

Approximately 75% of all healthcare costs are related to merely a handful of chronic diseases of which many could be prevented or managed simply by behavior changes. If commonsense prevailed, therein lies the answer to the single most influential driver of cost and ironically, the single most difficult challenge—educating the public to compel to them to change their lifestyle. However, it is a challenge America must engage in with renewed strategy and perseverance to contain this trend.

For diabetes alone, there is an approximate $174 billion expended of which $116 billion goes toward direct medical costs. The other $58 billion is associated with indirect costs such as work loss, disability or premature death (http://www.cdc.gov/nccdphp/overview.htm, retrieved February 15, 2009). "Almost half of Americans have some form of chronic illness" (O'Grady & Capretta, 2009). Add to this the predicted growth in the incidence and prevalence of chronic conditions. As those rates continue to climb, combined with the economic downturn, this predicament impinges on the ability of patients and Centers for Medicare and Medicaid Services (CMS) to pay. This creates financial stress for hospitals that may lead to a decrease in the services available to patients.

In a December 3, 2008 interview, Former Health and Human Services Secretary Mike Leavitt stated, "The more you anticipate the problem, the better chance you have of averting disaster" (Boston Globe as cited in Neumann, 2009). It seems America is anticipating the problem, but not taking strong action to avert the consequences. The Centers for Disease Control (CDC) states "diseases contributing most heavily to death, illness, and disability among Americans changed dramatically during the last century. Today, chronic diseases—such as cardiovascular (primarily heart disease and stroke), cancer, and diabetes—are among the most prevalent, costly, and preventable of all health problems." (http://www.cdc.gov/nccdphp/overview.htm, retrieved February 15, 2009).

In an age when the U.S. has the knowledge regarding the behaviors that would prevent many of these chronic conditions from occurring and the tools for screening and early detection, the point of impact is clear. The medical model presently used to manage these conditions is not working to prevent the future complications that arise from uncontrolled or unmonitored disease. Many health care providers and leaders readily admit the United States is in a rut of practicing

"sick care" versus "health care" and this will require cooperation from all players to work toward policy, environmental and organizational change.

The medical community needs to offer more wellness and prevention services. Communities need better education regarding the prevention of chronic diseases and the benefits of aggressive lifestyle changes in the early stages of chronic disease to thwart the debilitating outcomes that arise with delayed diagnosis and poor management. This may have more impact on future generations if incorporated in the early childhood education system and continued throughout highschool. More success may be possible with adults through employment or health insurance incentives. Any new approach and any change in policy will likely have unintended consequences, but this should not discourage attempts to experiment with new opportunities and track the results of different programs that have proven to have successful outcomes.

Recommendations

With approximately one forth of the state uninsured, Texas needs everyone on board to promote cohesive action. Federal elected officials need to make this a primary mission. The public and private sector need to organize and advocate in unified fashion to influence policy makers. Restructure is plausible as there is an increased urgency associated with the problem, organized groups continue to promote practical solutions and political circumstances are particularly intense. These are the "three streams of activity" that converge to open the agenda setting window (Longest, 2006).

It is not an easy task, but the conditions in the policymaking environment are more suitable now than they have been in several years and something will change. Bills are up for vote and what changes remains in question until the legislative session is over both at the state and federal level. The determining factor of reform in healthcare hinges on the public policy

issues presented at the state and federal level of greater scale and scope. Below are three recommendations to include maintaining status quo for the state and/or community level. As with any suggestion, the feasibility of implementation and political will are essential components guiding the change of choice that occurs.

Education & Redirection in the Emergency Department

This paper discussed the issue of increased use of the Emergency Department (ED) as a medical home for the un/underinsured, but insured individuals as well seek primary care from the ED. In other cases, it is the last resort of care for those with chronic conditions who delay care but now are suffering the complications from their condition and need medical attention. If individuals truly understood the "free" care they were getting indirectly generates a burden on society and becomes a bill they pay in another form, there is a very good chance that capturing them in the moment at the ED and educating them about other resources available could be truly cost-effective.

The "Navigation Service" is a phase of the program initiative "Gateway to Care" in Houston and it has promise. If combined with the CareLink program mentioned earlier, this could lead to cost savings that allow more services to a greater number of the Bexar County population. The program includes a "navigator" which is a certified community health worker (CHW). Through research, they know that approximately 52% of ED users did not need ED services. The navigators specifically address this area. They have the responsibility of talking to patients coming to the ED who could have received care via another avenue. They get the care they need, but time is taken to educate the patient about the choices available to them. The results from a pilot study conducted in three emergency centers showed the ED use declined 50% in the navigated group versus control groups. This is not considered a financially risky

endeavor considering the salary plus benefits for the CHW is approximately $43,000. The cost of a minor ED visit is estimated at $400. Therefore, if the navigators redirected 108 visits, the facility has already reached the breakeven point (C. Paret, personal communication, March 24, 2009).

The added benefit is that the population is educated and informed about what facilities are appropriate to utilize for care and they learn more about how to use nursing hotlines to assist in their decision to seek care as well. If this navigator concept was successfully implemented in the EDs in Bexar County in addition with the CareLink program, more individuals could be directed to the medical home for the indigent or could seek eligibility for social programs and it would be an added asset to a program that already proven benefits to Bexar County residents. These same models applied to more of the state could help not only cover more individuals but improve cost-effectiveness.

Acute to Chronic Care Model

The evidence presented in this paper illustrates the challenges that chronic conditions pose not only to the healthcare industry, but the welfare of the health and the economy of the nation. A strong course of action is needed to curb this insidious situation. It is more severe than any acute disease that was cured years go, which ironically, is a reason Americans are living longer to experience chronic conditions. The usual methods of medicine and economics are not going to curtail the problem ahead.

Mr. David Orszag, Chief White House Budget Director, in an April 6, 2009 interview recognizes, "Too many academic fields have tried to apply pure mathematical models to activities that involve human beings. And whenever that happens – whether it's in economics or health care or medical science – whenever human beings are involved, an approach that is

attracted by that purity will lead you astray" (NPR, 2009). It is time to deliver care in a different manner and find models worth implementing, the ones that have positive outcomes for population health. It is time to address the fact that practitioners are rushed for time inhibiting efforts to follow clinical practice guidelines or actively conduct follow-up care. Patients are not adequately trained to do self-management of their chronic conditions. If models for change do not appear to be cost-saving upfront, it should not divert the efforts to make the critical investment in America's future. "After all, the WHO says that eliminating chronic disease risk factors such as unhealthy diets, smoking, and physical inactivity could wipe out at least 80 percent of all heart disease, stroke, and type 2 diabetes worldwide" (Dentzer, 2009). In particular, one major effort needs to be in the area of care coordination. "At least one in five patients in all countries report that test results and records aren't available at the time of a medical appointment, or that doctors order tests that duplicate those already done" (Dentzer, 2009).

One example of a model worth consideration is the Chronic Care Model (CCM), developed by Ed Wagner and colleagues about ten years ago. The design of the CCM is to improve ambulatory care. The model consists of six interrelated system changes for improving the adoption of patient-centered, evidenced-based care to include delivery design, clinical information, decision support, self-management support, health care organization and community linkages. The CCM does require a multi-stakeholder approach, but most initiatives do, so not an unusual program detail.

This model's outcomes are encouraging. Health Affairs published a study that reviewed empirical evaluations of the CCM over the past decade which included addressing the feasibility of implementing and sustaining the model. RAND conducted that particular study one year out

from implementation and reported that 75% of the practices sustained changes. Additionally, compared to control practices, the intervention practice improvements showed that patients visited the emergency department less often and had 35% fewer hospital days, but saw no noteworthy changes in "intermediate outcomes such as hemoglobin A1c or blood pressure levels" (Coleman, Austin, Brach, & Wagner, 2009). Expanding follow-up to the three year mark, it was noted that after two years, significant improvements were seen in Hemoglobin A1C and low-density lipoprotein (LDL), labs that are considered positive changes for individuals with diabetes and/or heart disease. Coleman adds, this "bolstered emerging evidence that the collaborative learning structure and the CCM were effective models for improving care processes, although teams may have to wait to see real improvements in clinical outcomes" (Coleman, et al., 2009).

As stated by the President of the Texas Hospital Association, "Texas is the most obese, most hypertensive, and most diabetic state in the country" (D. Stultz, personal communication, October 14, 2008). These high value targets are presently in sight and projected to be an increasing threat on the resources available to help these conditions. Texas cannot afford to delay taking aim at these culprits of high cost, decreased longevity and diminished labor force.

Decrease third-party payers—Promote medical savings accounts

Considering some of the previously mentioned factors distorting consumers' understanding of the cost of healthcare and who pays for services rendered, moving to a method with direct payment from the supplier (physician) to buyer (patient) of healthcare services could have many benefits. As stated earlier, the population is accustomed to the idea of receiving medical benefits through an employer-provided mechanism. The wide acceptance of ESI is due to the tax exemptions to both the employer and employee if the medical care coverage is through

the employer. The federal programs that subsidize care contribute further to the disconnect between consumer and supplier. These mechanisms and programs to supply care, albeit with good intentions, have contributed to the escalating costs and are now deemed unsustainable if something does not change.

Perhaps the current situation validates movement along a similar direction (more ESI and more government assistance) is not a move in the right direction. Although, it may seem contrary to the health reform goals initially and upset the interests of many who are accustomed to business as usual, the idea by Milton Friedman may be a more viable option. The ideas in *How to Cure Health Care* present a mechanism for achieving cost savings while incorporating the concept that individuals need to have some personal responsibility in the system versus relying solely on a third party payer.

Essentially, Friedman suggests there be extension of tax exemptions to all medical care to remove the favoritism toward ESI. Additionally, promote and enhance the 1996 Kassebaum-Kennedy Bill authorizing medical savings accounts. Employees would have higher take home pay and the money deposited in a medical savings account is tax-free and may be used for medical expenses only. Except for retaining the need for catastrophic insurance, it is "a movement very much in the right direction," and the pilot studies conducted demonstrate that it "reduced costs for the employer and empowered the employee" (Friedman, 2001). Potentially, the full benefits of this option have positive ramifications for decreasing the number of uninsured, providing appropriate coverage to those underinsured for catastrophic events, and decreasing the administrative footprint. At a minimum, this option is worth reviewing to gauge if proposed reform is moving toward an effective or inadequate path.

Status Quo

Texas, San Antonio Bexar County has the liberty to allow status quo in this area. There is no legal requirement to pursue change. However, if there are different results desired, Patricia Santy makes a humorous but applicable point, "Doing the same thing over and over and expecting different results is not necessarily *insanity*; but it is clearly *psychological denial*, which, when indulged in for a prolonged period of time closely resembles insanity..." (http://drsanity.blogspot.com/2009/01/definition-of-insanity.html, retrieved April 1, 2009). If issues are not addressed with new actions, one cannot realistically expect improvements in healthcare coverage for Texans by maintaining status quo.

Discussion

Health policy does not exist in a vacuum. Clear-cut solutions are rare. There are a number of 'sides' to any particular problem and any potential solution will have supporters and detractors. The number, ratio, and intensity of these supporters or detractors are determined by the impact of the problem. In terms of a solution, those who take position determine these characteristics (Longest, 2006).

The conundrum with trying to deliver on all the areas of access, quality and cost is that implementing change, in the name of improvement, will have some tradeoffs. For example, healthcare coverage for the entire country will likely require mandates, which decrease the opportunity for individual choice and preferences. Decision makers will never have perfect information to balance trade-offs for each individual at any given time.

Therefore, to prepare Americans for the reality of what change truly means, perhaps it is best to replace "solution" with "trade-off" to emphasize that one person or one group will lose something if another is to gain. The same applies to any recommendation put forth regarding

change of healthcare practices to cover more un/underinsured. A plan to educate citizens on this reality may prove helpful in gaining support for the tough decisions.

The decisions will require a movement to unify community goals and individual stakeholders, pool resources and take action—new actions. No matter what decision passes in the legal system, Craig Westover has a unique point that would be good to keep in mind. "A world as it should be cannot tolerate individual liberty and free choice lest choices are made that make that world less than it should be; conversely, a free society will never be perfect; individuals in a free society will always make less than perfect choices" (Westover, 2008).

Knowing any choice will be imperfect gives no justification to stop moving forward and refrain from making decisive actions in effort to enhance lives. Texas leaders will never make the right decision for everyone, but when it come to the status of Texas healthcare, staying neutral is unacceptable. Texas must remain undaunted by the onerous task and be willing to take deliberate risks with confidence this state has a strong support system of caring professionals and citizens to handle the results.

APPENDIX A

Understanding Estimates of the Uninsured: Putting the Differences in Context

Selected Differences Between Surveys' Uninsured Estimates

Survey	Length of Time Uninsurance Measured	Respondent Recall Period	Sample Size	Most Recent Data From	Source of Data on Health Insurance Dynamics?	Source of State Estimates?
CPS	full year uninsured	Prior 14 months	132,324 (50,000 households)	1998	no	yes
SIPP	full year uninsured point in time ever uninsured during the year	Time of interview and prior 4 months	51,000 (20,000 households)	1994	yes	no
NHIS	full year uninsured point in time ever uninsured during the year	Time of interview and prior 12 months	103,477 (39,832 households)	1997	no	only for large states
MEPS	full year uninsured point in time ever uninsured during the year	Time of interview and prior 3-5 months	24,000 (9,400 households)	1996	yes	no
NSAF	full year uninsured point in time ever uninsured during the year	Time of interview and prior 12 months	100,000 (44,000 households)	1997	no	only for 13 states
CTS	full year uninsured point in time	Time of interview and prior 12 months	60,446 (33,000 households)	1996	no[7]	no

Table 1. (Retrieved from http://aspe.hhs.gov/health/reports/05/est-uninsured/report.pdf, March 10, 2009)

APPENDIX B

World Health Statistics 2008

Healthcare indicators for eight countries

	Australia	Canada	France	Germany	Japan	New Zealand	United Kingdom	United States
Health expenditures per capita ($)*[1]	2876	3165	3159	3005	2249	2083	2546	6102
Life expectancy at age 60*[2]	18.2	17.7	18.4	17.5	19.6	17.1	16.9	16.6
Deaths amenable to medical care/100 000 population*[2]	88	92	75	106	81	109	130	115
Access problems (%)†*[3]	34	26	n/a	28	n/a	38	13	51
Breast cancer 5 year survival (%)*[1]	80.0	82.0	79.7	78.0	79.0	79.0	80.0	88.9
Myocardial infarction 30 day hospital mortality (%)*[1]	8.8	12.0	8.0	11.9	10.3	10.9	11.0	14.8
Deaths from surgical or medical mishaps/ 100 000 population (2004)*[1]	0.4	0.5	0.5	0.6	0.2	n/a	0.5	0.7

*Average of male and female healthy life expectancies. †Percentage of adults with health problems who did not fill prescription or skipped doses, had a medical problem but did not visit doctor, or skipped test, treatment, or follow-up in the past year because of costs.

Table 3. (Retrieved from http://www.who.int/countries/usa/en/, September 23, 2008)

APPENDIX C

Hospital Payer Types

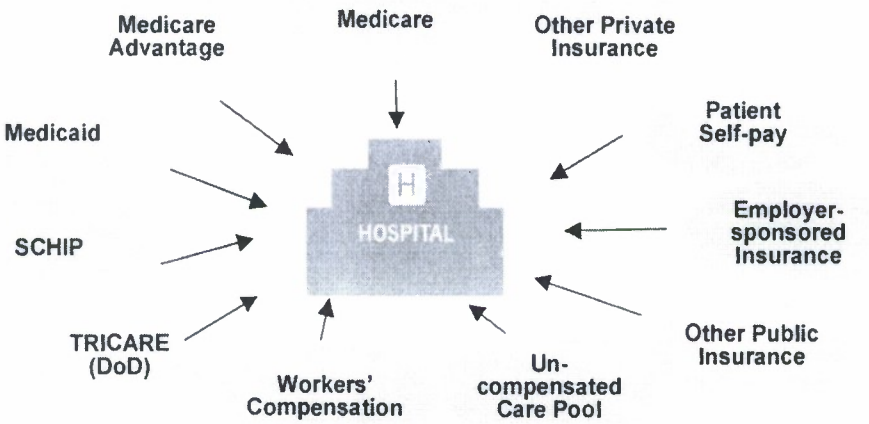

Figure 1. (Retrieved from http://www.aha.org/aha/trendwatch/2008/twjuly2008admburden.pdf, September 16, 2008)

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